HealthSelect

HealthSelect is a managed care plan specifically designed for Maricopa County employees and their eligible dependents. The plan offers a rich array of benefits as well as incentives toward wellness that include:

Direct access to OBGYN Care with incentives for obtaining well woman exams and mammograms and immunizations with incentives provided when they are received in the prescribed time frames

Members must use contracted providers, except in the case of an emergency. Maricopa Integrated Health Systems (MIHS) includes twelve (12) Family Health Centers (FHCs), a Comprehensive Health Center (CHC), and an extensive network of private practice physicians, ancillary providers and hospitals. MIHS expects that its contracted delivery system will refer to the contracted network. .

Eligibility Requirements

Members must meet the criteria stated for employee benefits to be eligible for HealthSelect. Eligible individuals include:

- An employee of Maricopa County
- An eligible dependent of a Maricopa County employee

Physicians are strongly encouraged to check eligibility to ensure member's status at the time services are rendered.

Quality Management

MIHS-HP contracted providers agree to participate in MIHS-HP's quality improvement processes. Quality Management includes credentialing, recredentialing, facility audits and active participation in surveys. Direct any concerns regarding quality to our Quality Management Department. MIHS-HP will investigate quality issues.

Utililzation Management

MIHS-HP contracted providers agree to participate in all aspects of its utilization program including but not limited to prior authorization, case management, discharge planning and medical review.

Formulary

MIHS-HP has a closed formulary and expects its physicians to use the drugs listed on the formulary. Should a formulary drug not be appropriate for your member, please request a non-formulary drug via fax or telephone to MIHS-HP. Requests for additons to the formulary should be directed to the MIHS-HP Medical Director. Requests for inclusion will be reviewed by the Pharmacy and Therapeutics Committee.

HealthSelect continued

Service or Procedure	Phone Number	Fax Number
After Hours Authorizations	344-8111	344-8458
Hospitalization Requests/Notifications:		
Inpatient hospitalizations	344-8111	344-8458
Pre-admissions for elective surgery		
Observation Unit		
Outpatient services:		
Outside of the service area provider Contracted provider	344-8480	344-8480
Skilled Nursing Facilities	344-8734	344-8348
Rehabilitation	344-8734	344-8348
OB Authorizations/Notifications:		
Delivery notifications	344-8111	344-8458
Prenatal care/global OB services		
Pharmacy:		
Non-Formulary Drug Request	344-8451	344-8858
Drugs requiring prior authorization		
Intravenous infusion (IV) non-formulary hydration		
TPN (total parenteral nutrition)		
Dental:		
Dental Evaluations	344-8111	344-8458
Dentures	344-8483 344-8825 344-8859	344-8706 344-8524
Supplies/Equipment (DME):		
Durable Medical Equipment	344-8483 344-8825 344-8859 344-8734	344-8706 344-8524 344-8348
Oxygen	344-8111	344-8458
Prosthetics, Orthotics, Braces	344-8483 344-8825 344-8859	344-8706 344-8524
Home Care Services:		
Home Health Aid Home Uterine Monitoring	344-8483 344-8825 344-8859	344-8706 344-8524
Home Health Care	344-8734	344-8706

HealthSelect continued

Prior authroization continued

Home Health Nursing	344-8784	344-8706
Other:		
Allergy consults & testing	344-8483 344-8825 344-8859	344-8706 344-8524
Attendant Care	344-8483 344-8825 344-8859	344-8706 344-8524
Dexa Scans	344-8111	344-8458
Dialysis	344-8310	344-8348
Dialysis – Out of Network	344-8111	344-8458
Disease Management Programs	344-8310	344-8348
Hospice	344-8784	344-8706
Infertility	344-8483 344-8825 344-8859	344-8706 344-8524
Medi-sets	344-8483 344-8825 344-8859	344-8706 344-8524
Transportation/Non emergency ambulance	344-8111	344-8458
Podiatry care in a skilled setting – Non-Medicare	344-8111	344-8458
Podiatry outpatient Care	344-8111	344-8458
Nutritional supplements	344-8483 344-8825 344-8859	344-8706 344-8524
Pain Management	344-8483 344-8825 344-8859	344-8706 344-8524
Seating Evaluations	344-8483 344-8825 344-8859	344-8706 344-8524
Sleep Studies	344-8483 344-8825 344-8859	344-8706 344-8524
Therapies: Pulmonary, Respiratory, Cardiac Rehab, OT, Speech, PT	344-8483 344-8825 344-8859	344-8706 344-8524
Transplants or related care	344-8310	344-8348

Certificates of Medical Necessity

A Certificate of Medical Necessity (CMN) must accompany orders for DME services and supplies.

HealthSelect continued

Outside Service Request

Some services require the completion of the Outside Services Request (OSR). An example of an OSR is provided in this manual. Examples of services that require an OSR are Durable Medical Equipment (DME) and Physical Therapy.

Mail or fax OSRs to:
MIHS-HP
2502 E University
Suite B1
Phoenix AZ 85034

Fax to: 344-8706 or 344-8524

In the course of arranging for some services, you may be required to provide the following documentation:

Durable Medical Equipment	Signed OSR Progress Notes or justification for equipment Certificate of Medical necessity (CMN)
Hospice	Physician Order
Nursing Home Placement	Current History and Physical Current medication and treatment orders Current TB test\Chest X-ray All problem lists Lab results Physician Progress Notes Any consult or therapy evaluations Immunization records
Therapy	Signed OSR
Specialty Providers	Information regarding the referral to the receiving provider
PCPs or Specialists	Information or reports back to the referring provider
All Providers	Communicate with all treating providers as needed when informed by Member of other treatment

Claims Submission

MIHS-HP processes clean claims within thirty (30) working days of receipt. A clean claim contains all the elements necessary to process the claim. Claims must be submitted no later than six (6) months from the date of service to be eligible for payment. Charges for professional fees must be submitted using a HCFA 1500 form. Charges for inpatient or non-professional type services must be submitted using a UB92 form. The claims section of this manual will provide detailed instructions on submission.

HealthSelect continued

Encounter Data & Reporting Requirements

Providers of service must ensure that encounter data and reporting requirements (including medical records) are complete and accurate.

Emergency & Urgent Care Services

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the women or her unborn child
- Serious impairment to bodily function, or
- Serious dysfunction of any bodily organ or part

Emergency services means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition

Urgently needed services means covered services provided when an enrollee is temporarily absent from the health plan service area (for a period of up to 12 months) when such services are medically necessary and immediately required

- As a result of an unforeseen illness injury or condition,
- It was not reasonable given the circumstances to obtain the services through MIHS-HP

Note: *MIHS-HP is responsible for the cost of post stabilization care provided outside the plan, if the care was approved by MIHS-HP. MIHS-HP is also responsible if the care was not pre-approved, because MIHS-HP did not respond to the post stabilization care provider's request for pre-approval within 1 hour after the request, or MIHS-HP could not be contacted for pre-approval.* ***Post stabilization care*** *is medically necessary, non-emergent services needed to ensure that the member remains stabilized from the time that the treating hospital requests authorization from MIHS-HP until the member is discharged, a plan physician arrives and assumes responsibility for the member's care, or the treating physician and the Plan agree to another arrangement.*

Direct Access (through self-referral)

HealthSelect allows direct access of the following services when contracted providers are used:

- Chiropractic Care
- Alternative Medicine
- OBGYN
- Optometry

HealthSelect continued

Concurrent Review/Discharge Planning

HealthSelect must ensure continuity of care and integration of services through arrangements that include, but are not limited to:

- Use of a practitioner who is specifically designated as having primary responsibilities for coordinating the member's overall health
- An ongoing source of primary care
- Each provider, supplier, and practitioner maintains a member health record within MIHS-HP standards

Appeals and Grievances (except MSSP)

MIHS-HP members may file a grievance by calling Member Services 602/344-8760 or by submitting their grievance in writing to:

Maricopa Managed Care Systems
Grievance and Appeals Unit
2502 East University
Phoenix, Arizona 85034

Providers may file a grievance by writing to:

Maricopa Managed Care Systems
Grievance and Appeals Unit
2502 East University
Phoenix, Arizona 85034

All grievances, except those regarding claim denials, must be filed no later than sixty (60) days from the date of the adverse action, decision, or policy made by MIHS-HP. Grievances regarding claim denials must be filed in writing no later than twelve (12) months from the date of the service.

MIHS-HP will make a final decision on grievances within thirty (30) days of the filing of the grievance and dispute, unless both parties agree upon an extension in writing. If on the 25th day following the filing of the grievance, it appears additional time is required to review the case, MIHS-HP will send a letter to the grievant requesting a thirty (30) day extension. If the extension is not agreeable to the grievant, or if the grievant fails to return the letter, MIHS-HP will use the available information to make a decision within the thirty (30) day limit. If the 30th day falls on a Sunday or legal holiday, MIHS-HP will make a decision on the following business day.

Members and providers have the right to appeal the grievance decision rendered by MIHS-HP within fifteen (15) days of decision notification. AHCCCSA will consider the appeal decision.

HealthSelect

Prohibition on Interference with Advice from Health Care Professionals

HealthSelect may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising and/or advocating on behalf of a member about his/her health status, medical care, treatment options, risks, benefits, consequences of treatment or non-treatment. Furthermore, HealthSelect may not restrict a health care professional from providing the member an opportunity to refuse treatment or express preferences regarding future treatment.

Assessment and Treatment of Members with Complex or Serious Medical Conditions

Primary Care Physicians (PCPs) or attending physicians during outpatient, emergency or inpatient care will develop a treatment plan in coordination with appropriate medical personnel, case mangers, and/or MIHS-HP case management staff. Treatment plans must be developed for members with the following conditions:

- Transplants
- Brain tumor
- Closed Head injuries
- Myocardial infarction
- Asthma
- Ventilator dependent members
- Leukemia
- Trauma i.e. burn, amputations, spinal cord injuries
- AIDS
- Diabetes
- Sickle cell disease

HealthSelect Members must be informed of specific health care needs that require follow up and must receive, as appropriate, training in self-care and other measures they may take to promote their own health. Treatment plans must be monitored on a periodic basis.

Continued Access to Specialty Care

HealthSelect members have the right to continued access to specialists in the case of involuntary termination of a plan or a specialist. Members assigned to a specialist(s) who has terminated voluntarily or involuntarily are referred by their PCP to another specialist within the MIHS-HP network or to a non-contracted specialist (when one is not available in-network) arranged by HealthSelect.

Medical Records

MMCS providers and MSSP must safeguard the privacy of information that identifies a particular member. Information may be released to authorized persons only. In the case of a new MSO (Managed Services Organization) or PCP selection, medical records must be forwarded to the new PCP or MSO as soon as possible. Original medical records must only be released in accordance with Federal or State laws, court orders or subpoenas. Records must be maintained in an accurate and timely manner. Information regarding advance directives must be kept in a prominent place in the member's file. Clear and concise communication with the member in language that he/she understands regarding the risks, benefits and consequences of treatment or non-treatment, and the member's right to refuse treatment must all be documented in the member's file. Members and Providers must have timely access to records. Medical records must be maintained for at least six (6) years.

HealthSelect continued

Denials, Suspensions, and Terminations

HealthSelect must notify its providers at least sixty (60) days before implementation of any adverse action that would affect health care professionals and their ability to coordinate care. Examples include termination without cause and suspension of a provider's participation. Providers have the right to appeal such a determination and to have the appeal heard before a panel of her/his peers. Providers terminated or suspended for quality deficiencies must be reported to the appropriate governing body.

Prohibition Regarding Discrimination

HealthSelect and HCFA require that all providers adhere to all laws regarding discrimination, including Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975, the Americans with Disabilities Act and any laws applicable to recipients of Federal Funds. Health care providers may not discriminate against members based on race, gender, age, or disability. Providers must agree to provide benefits in a manner consistent with professionally recognized standards of health care, including all benefits covered by Medicare.

Communication between Providers

MSSP expects that Providers will communicate with each other regarding the needs of it's members in a timely fashion. This includes but is not limited to diagnostic results, treatment plans, social and economic factors that may or may not impact the treating physician's ability to care for his/her patient. Test results and other outcomes should be provided to the referring physician as well as the member's PCP as soon as possible. This communication should become a part of the patient's medical record.

Communication with Members

MSSP expects that Providers will communicate with its members in a timely fashion regarding their medical care. Clear and concise communication with the member in language and manner that he/she understands regarding the risks, benefits and consequences of treatment or non-treatment, and the member's right to refuse treatment must be clearly communicated. This communication must be documented in the member's file.

Members Rights and Responsibilities

- Members must have choice & timely access of a qualified Contracted Primary Care Physician including PCPs, Specialists and Emergency Care
- Members must have the right to be treated with dignity and respect and have the right to privacy
- Members must have the opportunity to engage in candid discussion of appropriate or Medically Necessary treatment options including active participation in the selection of treatment options.

- Members must provide physicians or other care providers the information necessary for treatment
- Members must follow treatment plans
- Members must behave in a manner that supports care provided to other patients and the general functioning of the facility

HealthSelect continued

- Members must Accept responsibility for Copayments or Coinsurance
- Members must review information regarding their benefits
- Members must ask questions of their Primary Care Physicians or Health Select regarding concerns related to treatment or financial issues.

Plan Hospitals

- Arrowhead Hospital
- Scottsdale Memorial Hospital - Osborne
- Scottsdale Memorial Hospital - Shea
- Phoenix Regional Medical Center
-Tempe St. Luke's Medical Center
-Wickenburg Regional Medical Center
- Maricopa Medical Center
- Maryvale Hospital
- Phoenix Baptist Hospital -
- Paradise Valley Hospital
- Mesa General Hospital

Plan Pharmacies

Selected Fry's Pharmacies
Selected United Drugs
Family Health Centers